OUT-PATIENT CLAIM FORM

Practitioners Name Dr. FirstName4 SecondName4

Practitioner's Official Stamp

Postal Address Nairobi, Kenya

Tel No. 258731332456 Mobile 2587352393332

Email testuser254@test.com

PATIENT'S PARTICULARS

Full Name of Patient PFirstName4 PSecondName4 Date of Birth 04/11/1920

Full Name of Member (if patient is a dependant) Specimen2 Sample2

Member's Tel No. 0720000004 Member No. 100004

Member's Employer Name Sample4 Company (K) Ltd Dept. /Branch Department4 Sample4

Have you suffered from this sickness in the past? YES NO

If YES, when did it start and how frequent is it? N/A

CONSULTATION/REFERRALS DIAGNOSIS:

TREATMENT PRESCRIBED

MEDICINES:	Prescription		Injection given		Dispensed		None	
RADIOLOGY:	X-Ray		MRI/Cat Scan		Other		Other	
PATHOLOGY:	Haematology		Microbiology		Biochemistry		Histology	

Hospital Name: Consultant Referred To: Specialty:

MEDICATION PRESCRIBED:

Sample 4, Sample 44

Dr's Signature TTTTT **Date** 02/10/2023

DECLARATION

I warrant the truth of the above statements. I have not withheld or misstated material information relating to this claim and have no objection to yourselves communicating with my medical doctor with regard to this claim.

Member's Signature YYYYYY **Date** 01/01/2023

UAP Insurance Company Limited
UAP Old Mutual Tower, Upperhill Road. P.O Box 43013-00100 Nairobi, Tel: +254 711 065 100 / +254 20 285 0000
Email: uapoutpatient@uapoldmutual.com Website: www.uapoldmutual.com